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Health Promotion Glossary

World Health Organization
Geneva

Division of Health Promotion, Education and Communications (HPR)
Health Education and Health Promotion Unit (HEP)

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This Health Promotion Glossary was prepared on behalf of WHO by Don Nutbeam, WHO Collaborating Centre for Health Promotion, Department of Public Health and Community Medicine, University of Sydney, Australia. A pre-publication of the glossary was prepared as a resource document for the Fourth International Conference on Health Promotion, *New Players for a New Era: Leading Health Promotion into the 21st Century*, Jakarta, Indonesia, 21-25 July 1997. The pre-publication was subsequently revised to account for the outcomes from that Conference, specifically the Jakarta Declaration on Leading Health Promotion into the 21st Century.

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Contents

Foreword: Moving towards a new public health

The first edition of this health promotion glossary of terms was published by WHO in 1986 as a guide to readers of WHO documents and publications. It met a useful purpose in clarifying the meaning and relationship between the many terms which were not in common usage at that time. This first edition of the glossary has been translated into several languages (French, Spanish, Russian, Japanese and Italian), and the terms defined have been widely used both within and outside WHO. The glossary was adapted and republished in German in 1990.

Much has happened since the publication of the glossary a decade ago. Most notably, in October 1986 the First International Conference on Health Promotion was held in Ottawa, Canada, producing what is now widely known as the **Ottawa Charter for Health Promotion**. This conference was followed by others which explored the major themes of the **Ottawa Charter** on healthy public policy (in Adelaide, 1988), and on supportive environments for health (in Sundsvall, 1991). These conferences have added greatly to our understanding of health promotion strategies and their practical application, as well as more fully accounting for issues of relevance to developing countries. This was taken a step further at the Fourth International Conference on Health Promotion, *New Players for a New Era: Leading Health Promotion into the 21st Century*, which was held in Jakarta, Indonesia, in July 1997.

Several WHO programmes and projects have been developed and implemented which have sought to translate health promotion concepts and strategies into practical action. These include the **Healthy Cities, Villages, Municipalities** and **Healthy Islands** projects, the networks of **Health Promoting Schools** and **Health Promoting Hospitals**, and the **Healthy Marketplaces** and **Health Promoting Workplaces** projects, as well as WHO action plans on alcohol and tobacco, active living and healthy ageing.

Recent developments in health systems around the world have given new prominence to health promotion approaches. The increasing focus on health outcomes reconfirms the priority placed on investment in the determinants of health through health promotion. Continually asking the question "where is health created?" links health promotion to two major reform debates: the formulation of new public health strategies, and the need to re-orient health services. The foresight shown in the **Ottawa Charter** has been adopted by many countries and organizations around the world – a process which was taken one step further through the Fourth International Conference on Health Promotion in Jakarta, July 1997. This conference adopted the **Jakarta Declaration** on Leading Health Promotion into the 21st Century. A number of terms that are central to the **Jakarta Declaration** have therefore been included in this new version of the health promotion glossary.

Ilona Kickbusch
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January 1998

Introduction

With a decade of experience, and continued evolution and development of ideas since the production of the first glossary, this revision provides an updated overview of the many ideas and concepts which are central to contemporary health promotion. This time, as previously, the basic aim of the glossary is to facilitate communication both between countries and within countries, and among the various agencies and individuals working in the field. As before, the definitions should not be regarded as "the final word" on the terms included. As experience grows and ideas evolve further the terms will need to be regularly assessed for their meaning and relevance.

This version of the glossary is substantially different from the original. Some terms have been omitted, many have been modified in the light of experiences and evolution in concepts, and 19 new terms which are in current use have been included. The list of terms included is not intended to be either exhaustive or exclusive, and draws upon the wide range of disciplines from which health promotion has its origins. In a number of cases the definition adopted reflects the application of the term in the context of health promotion. This focus is acknowledged in the definition.

As in the original version, the definitions have been kept short, and make no pretence to offer fuller interpretations which may be found elsewhere in other publications. Where relevant, some notes of explanation have been added.

Similarly, the use of terms will often be situation-specific, and moulded by prevailing social, cultural and economic conditions. It will be apparent that some of the concepts and definitions that have been adopted in the glossary reflect the language and cultural bias of the principal author. Definitions by their very nature are restrictive, representing summaries of complex ideas and actions. Such restrictions are fully acknowledged in the drafting of the definitions used in this glossary.

Despite these obvious restrictions, the glossary has been assembled to enable as wide an audience as possible to understand the basic ideas and concepts which are central to the development of health promotion strategies and practical action. By clarifying the key terminology, this glossary is a part of the deliberate approach to engage as wide a constituency as possible in actions to promote health and prevent disease.

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January 1998

Notes

The glossary consists of two sections. The first contains seven core definitions which are central to the concept and principles of health promotion, and are discussed in greater detail. This is followed by the main section which includes an extended list of 54 terms which are commonly used in health promotion. The list is presented in alphabetical order.

Whenever possible, definitions have been taken or adapted from WHO publications – particularly in the case of core definitions. Most definitions are followed by a note of further explanation or qualification. When appropriate, the source of different terms in the main section of the glossary has been given in the text. Some of the definitions are original to the glossary, or are composites of definitions which reflect different perspectives to the term cited. The bibliography lists all the sources referred to directly in the text. Earlier drafts of this revision to the glossary were circulated to all Regional Offices of WHO for comment and consultation. Feedback from this process has resulted in important changes to several definitions in the glossary.

Many of the definitions are derived from the first version of the glossary published in 1986. Some remain identical to the early version (referred to by **Health Promotion Glossary, 1986**), but many have been modified to account for changes in use and evolution in concepts (referred to as **modified definition**).

Some terms within the definitions and notes are highlighted in *italics* to assist the reader in cross-referencing with other definitions. This cross referencing is intended to improve understanding of the inter-relationships between different terms and concepts.

Health Promotion Glossary
Section I: List of Basic Terms

Health

Health is defined in the WHO constitution of 1948 as:

> A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.
>
> Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life.
>
> Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.

Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986

In keeping with the concept of health as a fundamental human right, the **Ottawa Charter** emphasises certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to an holistic understanding of health which is central to the definition of health promotion.

Today the spiritual dimension of health is increasingly recognised. Health is regarded by WHO as a fundamental human right, and correspondingly, all people should have access to basic resources for health.

A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being.

See also *social responsibility for health*

Health promotion

> Health promotion is the process of enabling people to increase control over, and to improve their health.

Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986

Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people

to increase control over the *determinants of health* and thereby improve their *health*. Participation is essential to sustain health promotion action.

The **Ottawa Charter** identifies three basic strategies for health promotion. These are *advocacy* for health to create the essential conditions for health indicated above; *enabling* all people to achieve their full health potential; and *mediating* between the different interests in society in the pursuit of health.

These strategies are supported by five priority action areas as outlined in the **Ottawa Charter** for health promotion:

Build *healthy public policy*

Create *supportive environments for health*

Strengthen *community action for health*

Develop *personal skills, and*

Re-orient health services

Each of these strategies and action areas is further defined in the glossary.

The **Jakarta Declaration** on Leading Health Promotion into the 21st Century from July 1997 confirmed that these strategies and action areas are relevant for all countries. Furthermore, there is clear evidence that:

Comprehensive approaches to health development are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches;

Settings for health offer practical opportunities for the implementation of comprehensive strategies;

Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective;

Health literacy/ health learning fosters participation. Access to education and information is essential to achieving effective participation and the *empowerment* of people and communities.

For health promotion in the 21st century the **Jakarta Declaration** identifies five priorities:

Promote *social responsibility for health*

Increase *investments for health development*

Expand *partnerships for health promotion*

Increase community capacity and empower the individual

Secure an *infrastructure for health promotion*

Each of these priorities is further defined in the glossary. Increasing community capacity is addressed in the definition of *community action for health*. *Empowerment for health* is included as a definition.

Health for All

The attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life.

Reference: Glossary of Terms used in Health for All series. WHO, Geneva, 1984

Health for All has served as an important focal point for health strategy for WHO and its Member States for almost twenty years. Although it has been interpreted differently by each country in

the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system, it has provided an aspirational goal, based on the concept of *equity in health*. The Health for All strategy is currently being re-developed to ensure its continued relevance into the next century. A new policy is being developed, to be adopted by the World Health Assembly in 1998.

Public health

> The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.

Reference: adapted from the "Acheson Report", London, 1988

Public health is a social and political concept aimed at the improving health, prolonging life and improving the *quality of life* among whole populations through *health promotion, disease prevention* and other forms of health intervention. A distinction has been made in the *health promotion* literature between *public health* and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the *determinants of health*, and the methods of solving public health problems. This **new public health** is distinguished by its basis in a comprehensive understanding of the ways in which *lifestyles* and *living conditions* determine health status, and a recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy *lifestyles* and creating *supportive environments for health*. Such a distinction between the "old" and the "new" may not be necessary in the future as the mainstream concept of public health develops and expands.

The concept of **ecological public health** has also emerged in the literature. It has evolved in response to the changing nature of health issues and their interface with emerging global environmental problems. These new problems include global ecological risks such as the destruction of the ozone layer, uncontrolled and unmanageable air and water pollution, and global warming. These developments have a substantial impact on health which often elude simple models of causality and intervention.

Ecological public health emphasises the common ground between achieving *health* and *sustainable development*. It focuses on the economic and environmental *determinants of health*, and on the means by which economic investment should be guided towards producing the best population *health outcomes*, greater *equity in health*, and sustainable use of resources.

Primary health care

> Primary health care is essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable.

Reference: Alma Ata Declaration, WHO, Geneva, 1978

The Alma-Ata Declaration, also emphasises that everyone should have access to primary health care, and everyone should be involved in it. The primary health care approach encompasses the following key components: equity, *community* involvement/participation, intersectorality, appropriateness of technology and affordable costs.

As a set of activities, primary health care should include at the very least health education for individuals and the whole community on the size and nature of health problems, and on methods of preventing and controlling these problems. Other essential activities include the promotion of adequate supplies of food and proper nutrition; sufficient safe water and basic

sanitation; maternal and child health care, including family planning; immunization; appropriate treatment of common diseases and injuries; and the provision of essential drugs.

Primary health care as defined above will do much to address many of the pre-requisites for *health* indicated earlier. In addition, at a very practical level, there is great scope for both planned and opportunistic *health promotion* through the day to day contact between primary health care personnel and individuals in their community. Through *health education* with clients, and *advocacy* on behalf of their community, PHC personnel are well placed both to support individual needs and to influence the policies and programmes that affect the *health* of the *community*.

The primary health care concept and themes are currently being reviewed by WHO.

Disease prevention

> Disease prevention covers measures not only to prevent the occurrence of disease, such as *risk factor* reduction, but also to arrest its progress and reduce its consequences once established.

Reference: adapted from Glossary of Terms used in Health for All series. WHO, Geneva, 1984

Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation.

Disease prevention is sometimes used as a complementary term alongside *health promotion*. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the *health sector*, dealing with individuals and populations identified as exhibiting identifiable *risk factors*, often associated with different *risk behaviours*.

Health education

> Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve *health literacy*, including improving knowledge, and developing *life skills* which are conducive to individual and *community health*.

Reference: modified definition

Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve *health*. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on *health*, as well as individual *risk factors* and *risk behaviours*, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental *determinants of health*.

In the past, health education was used as a term to encompass a wider range of actions including social mobilization and *advocacy*. These methods are now encompassed in the term *health promotion*, and a more narrow definition of health education is proposed here to emphasize the distinction.

Health Promotion Glossary
Section II: Extended List of Terms

Advocacy for health

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.

Reference: Report of the Inter-Agency Meeting on Advocacy Strategies for Health and Development: Development Communication in Action. WHO, Geneva, 1995

Such action may be taken by and/or on behalf of individuals and groups to create *living conditions* which are conducive to *health* and the achievement of healthy *lifestyles*. Advocacy is one of the three major strategies for *health promotion* and can take many forms including the use of the mass media and multi-media, direct political lobbying, and *community* mobilization through, for example, coalitions of interest around defined issues. Health professionals have a major responsibility to act as advocates for *health* at all levels in society.

Alliance

An alliance for health promotion is a *partnership* between two or more parties that pursue a set of agreed upon goals in *health promotion*.

Reference: new definition

Alliance building will often involve some form of *mediation* between the different partners in the definition of goals and ethical ground rules, joint action areas, and agreement on the form of cooperation which is reflected in the alliance.

Community

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them.

Reference: modified definition

In many societies, particularly those in developed countries, individuals do not belong to a single, distinct community, but rather maintain membership of a range of communities based on variables such as geography, occupation, social and leisure interests.

Community action for health

Community action for health refers to collective efforts by communities which are directed towards increasing community control over the *determinants of health,* and thereby improving *health.*

Reference: new definition

The *Ottawa Charter* emphasises the importance of concrete and effective *community* action in setting priorities for *health*, making decisions, planning strategies and implementing them to achieve better health. The concept of community *empowerment* is closely related to the Ottawa Charter definition of community action for health. In this concept an empowered community is one in which individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective health needs. Through such participation, individuals and organizations within an empowered community provide *social support for health*, address conflicts within the *community,* and gain increased influence and control over the *determinants of health* in their *community*.

Determinants of health

The range of personal, social, economic and environmental factors which determine the *health status* of individuals or populations.

Reference: new definition

The factors which influence health are multiple and interactive. *Health promotion* is fundamentally concerned with action and *advocacy* to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as *health behaviours* and *lifestyles*, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different *living conditions* which impact on health. Achieving change in these *lifestyles* and *living conditions,* which determine *health status*, are considered to be *intermediate health outcomes*.

Empowerment for health

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health.

Reference: new definition

Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Through such a process people see a closer correspondence between their goals in life and a sense of how to achieve them, and a relationship between their efforts and life outcomes. *Health promotion* not only encompasses actions directed at strengthening the basic *life skills* and capacities of individuals, but also at influencing underlying social and economic conditions and physical environments which impact upon *health*. In this sense *health promotion* is directed at creating the conditions which offer a better chance of there being a relationship between the efforts of individuals and groups, and subsequent *health outcomes* in the way described above.

A distinction is made between individual and **community empowerment.** Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to

gain greater influence and control over the *determinants of health* and the *quality of life* in their *community*, and is an important goal in *community action for health*.

Enabling

> In health promotion, enabling means taking action in *partnership* with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their *health*.

Reference: new definition

The emphasis in this definition on *empowerment* through *partnership*, and on the mobilization of resources draws attention to the important role of health workers and other health activists acting as a catalyst for health promotion action, for example by providing access to information on health, by facilitating skills development, and supporting access to the political processes which shape public policies affecting *health*.

Epidemiology

> Epidemiology is the study of the distribution and determinants of health-states or events in specified populations, and the application of this study to the control of health problems.

Reference: Last, JM. Dictionary of Epidemiology. UK, 1988

Epidemiological information, particularly that defining individual, population and/or physical environmental risks has been at the core of *public health*, and provided the basis for *disease prevention* activities. Epidemiological studies use social classifications (such as socioeconomic status) in the study of disease in populations, but generally make less than optimal use of social sciences, including economic and public policy information, in investigating and understanding disease and *health* in populations.

Social epidemiology has evolved as a discipline during the past two decades. Social epidemiology is the study of *health* and illness in populations which is informed by a social, psychological, economic and public policy information, and uses that information in the definition of *public health* problems and proposal of solutions. As the discipline of epidemiology further develops and expands such distinctions will be less important in the future.

Equity in health

> Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being.

Reference: Equity in health and health care. WHO, Geneva, 1996

The WHO global strategy of achieving *Health for All* is fundamentally directed towards achieving greater equity in health between and within populations, and between countries. This implies that all people have an equal opportunity to develop and maintain their *health*, through fair and just access to resources for health. Equity in health is not the same as equality in *health status*. Inequalities in *health status* between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal *lifestyle* choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in *health status* arise as a consequence of inequities in opportunities in life.

Health behaviour

> Any activity undertaken by an individual, regardless of actual or perceived *health status*, for the purpose of promoting, protecting or maintaining *health*, whether or not such behaviour is objectively effective towards that end.

Reference: Health Promotion Glossary, 1986

It is possible to argue that almost every behaviour or activity by an individual has an impact on *health status*. In this context it is useful to distinguish between behaviours which are purposefully adopted to promote or protect *health* (as in the definition above), and those which may be adopted regardless of consequences to *health*. Health behaviours are distinguished from *risk behaviours* which are defined separately as behaviours associated with increased susceptibility to a specific cause of ill-health.

Health behaviours and *risk behaviours* are often related in clusters in a more complex pattern of behaviours referred to as *lifestyles*.

Health communication

> Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development.

Reference: adapted from Communication, Education and Participation: A Framework and Guide to Action. WHO (AMRO/PAHO), Washington, 1996

Health communication is directed towards improving the *health status* of individuals and populations. Much of modern culture is transmitted by the mass and multi media which has both positive and negative implications for *health*. Research shows that theory-driven mediated *health promotion* programming can put *health* on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy *lifestyles*.

Health communication encompasses several areas including edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can take many forms from mass and multi media communications to traditional and culture-specific communication such as story telling, puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas.

Advances in communication media, especially in the multi media and new information technology continue to improve access to health information. In this respect, health communication becomes an increasingly important element to achieving greater *empowerment* of individuals and *communities*.

Health development

> Health development is the process of continuous, progressive improvement of the *health status* of individuals and groups in a population.

Reference: Terminology Information System. WHO, Geneva, 1997

The **Jakarta Declaration** describes *health promotion* as an essential element of health development.

Health expectancy

Health expectancy is a population based measure of the proportion of expected life span estimated to be healthful and fulfilling, or free of illness, disease and disability according to social norms and perceptions and professional standards.

Reference: new definition

Health expectancy belongs to a new generation or type of health indicator which are currently being developed. These indicators are intended to create measures which are more sensitive to the dynamics of health and *determinants*. Health expectancy indicators combine information from life expectancy tables and health surveys of populations. They need to be based on life expectancy at country level or a similar geographic area.

Examples of health expectancy indicators currently in use are disability free life years (DFLY) and quality adjusted life years (QALY). They focus primarily on the extent to which individuals experience a life span free of disability, disorders and/or chronic disease. *Health promotion* seeks to expand the understanding of health expectancy beyond the absence of disease, disorder and disability towards positive measures of health creation, maintenance and protection, emphasizing a healthy life span.

Health gain

Health gain is a way to express improved *health outcomes*. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain.

Reference: new definition

The Jakarta Declaration indicates that health promotion "acts on the *determinants of health* to create the greatest health gain for people."

See also *health outcome* and *intermediate health outcomes*

Health goal

Health goals summarize the *health outcomes* which, in the light of existing knowledge and resources, a country or *community* might hope to achieve in a defined time period.

Reference: new definition

Health goals are general statements of intent and aspiration, intended to reflect the values of the *community* in general, and the *health sector* in particular, regarding a healthy society. Many countries have adopted an approach to setting health goals and *health targets* as statement of direction and intent with regard to their *investments for health*. WHO has supported the development, and promoted the use of health goals and targets at global and regional, national and local levels.

Health indicator

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Reference: modified definition

Health indicators can be used to define *public health* problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a programme are being reached.

Health indicators may include measurements of illness or disease which are more commonly used to measure *health outcomes*, or positive aspects of health (such as *quality of life*, *life skills*, or *health expectancy*), and of behaviours and actions by individuals which are related to health. They may also include indicators which measure the social and economic conditions and the physical environment as it relates to health, measures of *health literacy* and *healthy public policy*. This latter group of indicators may be used to measure *intermediate health outcomes*, and *health promotion outcomes*.

Health literacy

> Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good *health*.

Reference: new definition

Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal *lifestyles* and *living conditions*. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to *empowerment*. Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people's *health* directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy.

Health outcomes

> A change in the *health status* of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change *health status*.

Reference: new definition

Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including *health promotion* programmes. It may also include the intended or unintended health outcomes of government policies in sectors other than health. Health outcomes will normally be assessed using *health indicators*. See also *intermediate health outcomes*, and *health promotion outcomes*.

Health policy

> A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures.

Reference: modified definition

Health policy is often enacted through legislation or other forms of rule-making which define regulations and incentives which enable the provision of health services and programmes, and access to those services and programmes. Health policy is currently distinguished from *healthy public policy* by its primary concern with health services and programmes. Future progress in health policies may be observed through the extent to which they may also be defined as *healthy public policies.*

As with most policies, health policies arise from a systematic process of building support for *public health* action that draws upon available evidence, integrated with community preferences, political realities and resource availability.

Health promoting hospitals

> A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of *health promotion*, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment and actively co-operates with its *community.*

Reference: based on Budapest Declaration on Health Promoting Hospitals. WHO, (EURO), Copenhagen, 1991

Health promoting hospitals take action to promote the *health* of their patients, their staff, and the population in the community they are located in. Health promoting hospitals are actively attempting to become "healthy organizations". Health Promoting Hospitals are being implemented since 1988. An international network has developed to promote the wider adoption of this concept in hospitals and other health care settings.

Health promoting schools

> A health promoting school can be characterized as a school constantly strengthening its capacity as a healthy setting for living, learning and working.

Reference: Promoting health through schools. Report of a WHO Expert Committee on Comprehensive School Health Education and Promotion. WHO Technical Report Series N°870. WHO, Geneva, 1997

Towards this goal, a health promoting school engages *health* and education officials, teachers, students, parents and community leaders in efforts to promote health. It fosters *health* and learning with all the measures at its disposal, and strives to provide *supportive environments for health* and a range of key school *health education* and promotion programs and services. A health promoting school implements policies, practices and other measures that respect an individual's self esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements. It strives to improve the health of school personnel, families and community members as well as students, and works with community leaders to help them understand how the *community* contributes to *health* and education.

WHO's Global School Health Initiative aims at helping all schools to become "health promoting" by, for example, encouraging and supporting international, national and subnational networks of health promoting schools, and helping to build national capacities to promote health through schools.

Health promotion evaluation

Health promotion evaluation is an assessment of the extent to which *health promotion* actions achieve a "valued" outcome.

Reference: new definition

The extent to which *health promotion* actions *enable* individuals or communities to exert control over their *health* represents a central element of health promotion evaluation.

In many cases it is difficult to trace the pathway which links particular health promotion activities to *health outcomes*. This may be for a number of reasons, for example, because of the technical difficulties of isolating cause and effect in complex, "real-life" situations. Therefore, most recent outcome models in *health promotion* distinguish between different types of outcomes and suggest a hierarchy among them. *Health promotion outcomes* represent the first point of assessment and reflect modifications to those personal, social and environmental factors which are a means to improve people's control over their *health*. Changes in the *determinants of health* are defined as *intermediate health outcomes*. Changes in *health status* represent *health outcomes*.

In most cases, there is also "value" placed on the process by which different outcomes are achieved. In terms of valued processes, evaluations of health promotion activities may be **participatory**, involving all those with a vested interest in the initiative; **interdisciplinary**, by involving a variety of disciplinary perspectives; **integrated** into all stages of the development and implementation of a health promotion initiative; and help build the capacity of individuals, *communities*, organizations and governments to address important health problems.

Health promotion outcomes

Health promotion outcomes are changes to personal characteristics and skills, and/or social norms and actions, and/or organizational practices and public policies which are attributable to a *health promotion* activity.

Reference: new definition

Health promotion outcomes represent the most immediate results of *health promotion* activities and are generally directed towards changing modifiable *determinants of health*. Health promotion outcomes include *health literacy*, *healthy public policy*, and *community action for health*. See also *health outcomes* and *intermediate health outcomes*.

Health sector

The health sector consists of organized public and private health services (including *health promotion*, *disease prevention*, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related non-government organizations and *community* groups, and professional associations.

Reference: adapted from Glossary of Terms used in Health for All series N° 9. WHO, Geneva, 1984

Health status

A description and/or measurement of the *health* of an individual or population at a particular point in time against identifiable standards, usually by reference to *health indicators*.

Reference: adapted from Glossary of Terms used in Health for All series N° 9. WHO, Geneva, 1984

Health target

Health targets state, for a given population, the amount of change (using a *health indicator*) which could be reasonably expected within a defined time period. Targets are generally based on specific and measurable changes in *health outcomes*, or *intermediate health outcomes*.

Reference: new definition

Health targets define the concrete steps which may be taken towards the achievement of *health goals*. Setting targets also provides one approach to the assessment of progress in relation to a defined *health policy* or programme by defining a benchmark against which progress can be measured. Setting targets requires the existence of a relevant *health indicator* and information on the distribution of that indicator within a population of interest. It also requires an estimate of current and likely future trends in relation to change in the distribution of the indicator, and an understanding of the potential to change the distribution of the indicator in the population of interest.

Healthy cities

A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

Reference: Terminology for the European Conference on Health, Society and Alcohol: A glossary with equivalents in French, German and Russian. WHO (EURO), Copenhagen, 1995

The WHO Healthy Cities project is a long-term development project that seeks to place *health* on the agenda of cities around the world, and to build a constituency of support for *public health* at the local level. The healthy cities concept is evolving to encompass other forms of settlement including healthy villages and municipalities.

Healthy islands

A healthy island is one that is committed to and involved in a process of achieving better health and *quality of life* for its people, and healthier physical and social environments in the context of *sustainable development*.

Reference: adapted from Yanuca Island Declaration. WHO (WPRO), Manila, 1995

The **Yanuca Island Declaration** states that Healthy Islands are places where children are nurtured in body and mind; environments invite learning and leisure; people work and age in dignity; and ecological balance is a source of pride. This Declaration was ratified by the Health Ministers of fourteen Pacific Island nations in 1995 and has since become an inter-regional source of reference for Healthy Islands programmes throughout the world.

Healthy public policy

Healthy public policy is characterized by an explicit concern for *health* and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy

public policy is to create a *supportive environment* to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing.

Reference: Adelaide Recommendations on Healthy Public Policy. WHO, Geneva, 1988

The **Ottawa Charter** highlighted the fact that *health promotion* action goes beyond the health care sector, emphasizing that health should be on the policy agenda in all sectors, and at all levels of government. One important element in building healthy public policy is the notion of accountability for *health*. Governments are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policies means that governments must measure and report on their *investments for health*, and the subsequent *health outcomes*, and *intermediate health outcomes* of their investments and policies in a language that all groups in society readily understand. Closely related to the health promotion concept of healthy public policy is the strategy of *investment for health*. Investment for health is a strategy for optimizing the health promoting impact of public policies.

Infrastructure for health promotion

Those human and material resources, organizational and administrative structures, policies, regulations and incentives which facilitate an organized health promotion response to *public health* issues and challenges.

Reference: new definition

Such infrastructures may be found through a diverse range of organizational structures, including *primary health care*, government, private sector and nongovernmental organizations, *self-help* organizations, as well as dedicated health promotion agencies and foundations. Although many countries have a dedicated *health promotion* workforce, the greater human resource is to be found among the wider health workforce, workforces in other sectors than *health* (for example in education, social welfare and so on), and from the actions of lay persons within individual *communities*. Infrastructure for health promotion can be found not only in tangible resources and structures, but also through the extent of public and political awareness of health issues, and participation in action to address those issues.

Intermediate health outcomes

Intermediate health outcomes are changes in the *determinants of health*, notably changes in *lifestyles*, and *living conditions* which are attributable to a planned intervention or interventions, including *health promotion, disease prevention* and *primary health care*.

Reference: new definition

See also *determinants of health, health outcomes* and *intermediate health outcomes*

Intersectoral collaboration

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve *health outcomes* or *intermediate health outcomes* in a way which is more effective, efficient or sustainable than might be achieved by the *health sector* acting alone.

Reference: modified from Intersectoral Action for Health: A Cornerstone for Health for All in the 21st Century. WHO, Geneva, 1997

Intersectoral action for health is seen as central to the achievement of greater *equity in health*, especially where progress depends upon decisions and actions in other sectors, such as agriculture, education, and finance. A major goal in intersectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of *healthy public policy* and practice. Not all intersectoral action for health need involve the *health sector*. For example, in some countries the police and transport sectors might combine to take action to reduce road transport injury. Such action, although explicitly intended to reduce injury, will not always involve the *health sector*. Increasingly intersectoral collaboration is understood as cooperation between different sectors of society such as the public sector, civil society and the private sector.

Investment for health

> Investment for health refers to resources which are explicitly dedicated to the production of *health* and *health gain*. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the *determinants of health* and seek to gain political commitment to *healthy public policies*.

Reference: new definition

Investment for health is not restricted to resources which are devoted to the provision and use of health services and may include, for example, investments made by people (individually or collectively) in education, housing, empowerment of women or child development. Greater investment for health also implies reorientation of existing resource distribution within the *health sector* towards *health promotion* and *disease prevention*. A significant proportion of investments for health are undertaken by people in the context of their everyday life as part of personal and family health maintenance strategies.

See also *healthy public policy* and *supportive environments for health*

Jakarta Declaration on Leading Health Promotion into the 21st Century

See *health promotion* (section I)

Life skills

> Life skills are abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life.

Reference: Life skills education in schools. WHO, Geneva, 1993

Life skills consist of personal, inter-personal, cognitive and physical skills which enable people to control and direct their lives, and to develop the capacity to live with and produce change in their environment. Examples of individual life skills include decision making and problem solving, creative thinking and critical thinking, self awareness and empathy, communication skills and interpersonal relationship skills, coping with emotions and managing stress. Life skills as described above are fundamental building blocks for the development of *personal skills* for *health promotion* described as one of the key action areas in the **Ottawa Charter**.

Lifestyle (lifestyles conducive to health)

> Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental *living conditions*.

Reference: modified definition

These patterns of behaviour are continually interpreted and tested out in different social situations and are therefore not fixed, but subject to change. Individual lifestyles, characterized by identifiable patterns of behaviour, can have a profound effect on an individual's health and on the health of others. If *health* is to be improved by enabling individuals to change their lifestyles, action must be directed not only at the individual but also at the social and *living conditions* which interact to produce and maintain these patterns of behaviour.

It is important to recognize, however, that there is no "optimal" lifestyle to be prescribed for all people. Culture, income, family structure, age, physical ability, home and work environment will make certain ways and conditions of living more attractive, feasible and appropriate.

Living conditions

> Living conditions are the everyday environment of people, where they live, play and work. These living conditions are a product of social and economic circumstances and the physical environment – all of which can impact upon *health* – and are largely outside of the immediate control of the individual.

Reference: modified definition

The *Ottawa Charter* action of creating *supportive environments for health* is largely focused on the need to improve and change living conditions to support health.

Mediation

> In *health promotion*, a process through which the different interests (personal, social, economic) of individuals and *communities*, and different sectors (public and private) are reconciled in ways that promote and protect health.

Reference: new definition

Producing change in people's *lifestyles* and *living conditions* inevitably produces conflicts between the different sectors and interests in a population. Such conflicts may arise, for example, from concerns about access to, use and distribution of resources, or constraints on individual or organizational practices. Reconciling such conflicts in ways which promote health may require considerable input from health promotion practitioners, including the application of skills in *advocacy for health*.

Network

> A grouping of individuals, organizations and agencies organized on a non hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust.

Reference: new definition

WHO actively initiates and maintains several *health promotion* networks around key *settings* and issues. These include, for example, the intersectoral *healthy cities* network, networks of *health promoting schools*, and WHO country networks for health promotion such as the WHO mega country initiative. Networks of networks are also being established. Examples include the WHO(EURO) initiative "Networking the networks" and global networking initiatives for health promotion in order to build a global *alliance* for *health promotion*.

Ottawa Charter for Health Promotion

See *Health Promotion* (section I)

Partnership for health promotion

> A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared *health outcomes*.

Reference: new definition

Such partnerships may form a part of *intersectoral collaboration* for health, or be based on *alliances* for health promotion. Such partnerships may be limited by the pursuit of a clearly defined goal – such as the successful development and introduction of legislation; or may be on-going, covering a broad range of issues and initiatives. Increasingly *health promotion* is exploring partnerships between the public sector, civil society and the private sector.

See also *social responsibility for health* and *primary health care* (section I)

Personal skills

See *life skills*

Quality of life

> Quality of life is defined as individual's perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment.

Reference: Quality of Life Assessment. The WHOQOL Group, 1994. What Quality of Life? The WHOQOL Group. In: World Health Forum. WHO, Geneva, 1996.

This definition highlights the views that quality of life refers to a subjective evaluation, which induces both positive and negative dimensions, and which is embedded in a cultural, social and environmental context. WHO identified six broad domains which describe core aspects of quality of life cross-culturally: a physical domain (e.g. energy, fatigue), a psychological domain (e.g. positive feelings), level of independence (e.g. mobility), social relationships (e.g. practical social support), environment (e.g. accessibility of health care) and personal beliefs/spirituality (e.g. meaning in life). The domains of *health* and quality of life are complementary and overlapping.

Quality of life reflects the perception of individuals that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfilment, regardless of physical *health status*, or social and economic conditions. The goal of improving the quality of life, alongside preventing avoidable ill-health, has become of increased importance in *health promotion*. This is particularly important in relation to meeting the needs of older people, the chronically sick, terminally ill, and disabled populations.

Re-orienting health services

> Health services re-orientation is characterized by a more explicit concern for the achievement of population *health outcomes* in the ways in which the health system is organized and funded. This must lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person, balanced against the needs of population groups.

Reference: adapted from Ottawa Charter for Health Promotion. WHO, Geneva, 1986

The **Ottawa Charter** also emphasizes the importance of a *health sector* which contributes to the pursuit of health. Responsibility for achieving this is shared between all the health professions, health service institutions and government, alongside the contribution of individuals and communities served by the *health sector*. In most cases this will require an expansion in *health promotion* and *disease prevention* action to achieve an optimal balance between investments in health promotion, illness prevention, diagnosis, treatment, care and rehabilitation services. Such an expanded role need not always be achieved through an increase in direct health system activity. Action by sectors other than the *health sector* may be more effective in achieving improved *health outcomes*. Governments need to acknowledge the key role of the *health sector* in supporting such inter-sectoral action for health.

See also *Health Promoting Hospitals*

Risk behaviour

> Specific forms of behaviour which are proven to be associated with increased susceptibility to a specific disease or ill-health.

Reference: modified definition

Risk behaviours are usually defined as "risky" on the basis of epidemiological or other social data. Changes in risk behaviour are major goals of *disease prevention*, and traditionally *health education* has been used to achieve these goals. Within the broader framework of *health promotion*, risk behaviour may be seen as a response, or mechanism for coping with adverse *living conditions*. Strategies to respond to this include the development of *life skills*, and creation of more *supportive environments for health*.

Risk factor

> Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

Reference: modified definition

As is the case with *risk behaviours*, once risk factors have been identified, they can become the entry point or focus for *health promotion* strategies and actions.

Self help

In the context of *health promotion*, actions taken by lay persons (i.e. non health professionals) to mobilize the necessary resources to promote, maintain or restore the health of individuals or communities.

Reference: modified definition

Although self help is usually understood to mean action taken by individuals or *communities* which will directly benefit those taking the action, it may also encompass mutual aid between individuals and groups. Self help may also include self care – such as self medication and first aid in the normal social context of people's everyday lives.

Settings for health

The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing.

Reference: new definition

A setting is also where people actively use and shape the environment and thus create or solve problems relating to *health*. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure.

Action to promote health through different settings can take many different forms, often through some form of organizational development, including change to the physical environment, to the organizational structure, administration and management. Settings can also be used to promote *health* by reaching people who work in them, or using them to gain access to services, and through the interaction of different settings with the wider *community*. Examples of settings include schools, work sites, hospitals, villages and cities.

Social capital

Social capital represents the degree of social cohesion which exists in *communities*. It refers to the processes between people which establish *networks*, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit.

Reference: new definition

Social capital is created from the myriad of everyday interactions between people, and is embodied in such structures as civic and religious groups, family membership, informal community *networks*, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a *community* will co-operate for mutual benefit. In this way social capital creates *health*, and may enhance the benefits of *investments for health*.

Social networks

Social relations and links between individuals which may provide access to or mobilization of *social support* for *health*.

Reference: modified definition

A stable society is far more likely to have established social networks which provide access to *social support*. De-stabilizing influences such as high unemployment, re- housing

schemes, and rapid urbanization can lead to considerable dislocation of social networks. In such circumstances action to promote health might focus on support for re-establishing social networks.

Social responsibility for health

Social responsibility for health is reflected by the actions of decision makers in both public and private sector to pursue policies and practices which promote and protect *health*.

Reference: The Jakarta Declaration on Leading Health Promotion into the 21st Century. WHO, Geneva, 1997

The policies and practices pursued by the public and private sectors should avoid harming the *health* of individuals; protect the environment and ensure sustainable use of resources; restrict the production of and trade in inherently harmful goods and substances, as well as discourage unhealthy marketing practices; safeguard the citizen in the marketplace and the individual in the workplace, and include *equity*-focused health impact assessments as an integral part of policy development.

See also *healthy public policy*

Social support

That assistance available to individuals and groups from within *communities* which can provide a buffer against adverse life events and *living conditions*, and can provide a positive resource for enhancing the *quality of life*.

Reference: modified definition

Social support may include emotional support, information sharing and the provision of material resources and services. Social support is now widely recognized as an important *determinant of health*, and an essential element of *social capital*.

Supportive environments for health

Supportive environments for health offer people protection from threats to *health*, and enable people to expand their capabilities and develop self reliance in health. They encompass where people live, their local *community*, their home, where they work and play, including people's access to resources for health, and opportunities for *empowerment*.

Reference: adapted from Sundsvall Statement on Supportive Environments for Health. WHO, Geneva, 1991

Action to create supportive environments for health has many dimensions, and may include direct political action to develop and implement policies and regulations which help create supportive environments; economic action, particularly in relation to fostering sustainable economic development; and social action.

Sustainable development

Sustainable development is defined as development that meets the needs of the present without compromising the ability of future generations to meet their own

needs (WCED 1987). It incorporates many elements, and all sectors, including the *health sector*, which must contribute to achieve it.

Reference: Our common future: Report of the World Commission on Environment and Development (WCED), 1987. Health and Environment in Sustainable Development. Five years after the Earth Summit. WHO, Geneva, 1997

Human beings are at the centre of sustainable development. Sustainable development refers to the use of resources, direction of investments, the orientation of technological development, and institutional development in ways which ensure that the current development and use of resources do not compromise the *health* and well-being of future generations.

There is no single best way of organizing the complex development-environment-health relationship that reveals all the important interactions and possible entry points for *public health* interventions. In *health promotion*, sustainable development is particularly important in terms of building *healthy public policy*, and *supportive environments for health* in ways which improve *living conditions*, support healthy *lifestyles*, and achieve greater *equity in health* both now and in the future.

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Health Promotion Glossary is available on Internet via http://www.who.ch/hep

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

WHO is a specialized agency within the Charter of the United Nations and was established in 1948 by 61 Governments "for the purpose of co-operation among themselves and with others to promote the health of all people". The number of Member States has now grown to 191.

WHO represents the culmination of efforts at international health cooperation that started almost 150 years ago. In 1851, the first International Sanitary Conference was initiated to discuss measures against the importation of plague into Europe. Later on, nations joined forces to combat common threats such as yellow fever, cholera, smallpox and typhus. Other landmarks were the establishment of the Pan American Sanitary Bureau in 1902, the *Office International d'Hygiène Publique (OIHP)* in 1907, and the Health Organization of the League of Nations in 1919. In 1945, Brazil and China suggested the establishment of an international health organization leading to the Constitution of the WHO which was approved in 1946. The Constitution came into force on 7 April 1948 when the 26th of the 61 Member States who signed, ratified its signature.

WHO's main functions are:

- to give worldwide guidance in the field of health;
- to cooperate with governments to strengthen the planning, management and evaluation of national health programmes;
- to develop and transfer appropriate health technology, information and standards for human health.

Since the creation of WHO, there have been major accomplishments in global health. Among these are:

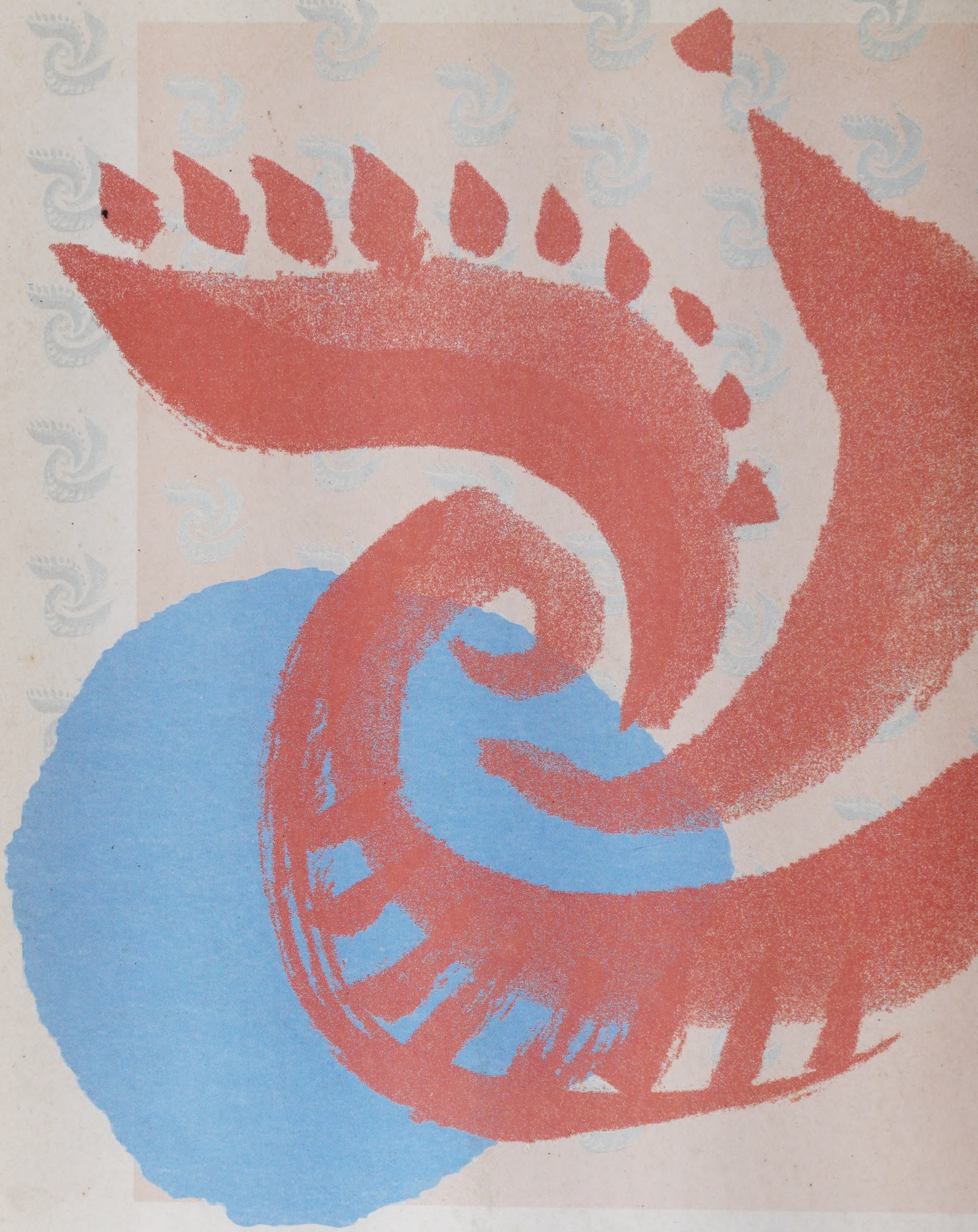
- fighting infectious diseases. For example, millions of children have been saved annually from death and disability, in part due to global immunization programmes
- providing health services
- reducing death, increasing life
- delivering essential drugs and
- making cities healthier.

Just as WHO eradicated smallpox in 1980, we are at the threshold of elimination of other major diseases in the next few years, such as poliomyelitis, guinea-worm disease and leprosy.

The challenges WHO still faces are:

- achieving health for all
- controlling old and new diseases
- achieving reproductive health for all
- building partnerships for health and
- promoting healthy lifestyles and environments.

Further information on many aspects of WHO's work is presented in the Organization's publications.



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